STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE & ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

Instate and Out-Of-State Individual Provider In Private Practice or Provider Joining A Group

In response to your interest in participating in the Tennessee TennCare/Medicaid Program, we are providing the necessary documents for enrollment.

Tennessee TennCare/Medicaid Providers must have completed application forms on file before claims can be processed for payment. Please complete all documents and return to:

Department of Finance and Administration
Bureau of TennCare
Provider Enrollment Unit
310 Great Circle Road
Nashville, TN 37243 – 1700

All incomplete applications and requested documents not included will be returned to the pay-to address on your application. All documents must have original signatures.

Tennessee Providers may obtain a copy of their licensure verification from the official website of the State of Tennessee, Department of Health listed below:

http://www2.state.tn.us/health/licensure/index.htm

Note: Out-Of-State Providers must return a claim form with an attached Medicare Remittance for dually-eligible Medicare/Medicaid recipients, or a claim form only if billing for a TennCare recipient.

Completed Applications will be assigned a Tennessee Medicaid Provider Number. You will be notified in writing of your assigned Provider Number. Please file all future claims only after you receive the notification as your provider number must be stated on all claim forms. Providers who have rendered a service to a TennCare only recipient will be required to enroll with the TennCare Managed Care Organization the recipient has chosen to manage his/her healthcare. The state Medicaid ID number assigned by this office should be presented to the MCO upon enrolling. You will be assigned a billing number by the MCO for reimbursement.

Should you have any questions regarding your number assignment, please contact: 1-800-852-2683, or (615) 741-6669.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 GREAT CIRCLE ROAD
NASHVILLE, TENNESSEE 37243 – 1700

CHECKLIST

Instate and Out-Of-State Individual Provider Joining A Group

This check list will assist you in completing and returning the correct forms along with this document. Enrollment Packets must include the following:

NPI Number _ _ _ _ _ _ _ _ _ _

NPI Collection Form _____

No. 2 Individual Application _____

Provider Participation Agreement _____

Substitute W-9 Form _____

Copy Of License _____

Copy Of License Renewal _____

Copy of Certification _____

Copy of Renewal _____

Cigna Medicare Part B Welcome Letter (Instate Only) _____

Claim Form (Out-Of-State Only) _____

Medicare Remittance (Out-Of-State Only) _____

Bureau of TennCare/Medicaid
Provider Enrollment

310 Great Circle Road
Nashville, TN 37243-1700

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
NO. 2 INDIVIDUAL APPLICATION
www.state.tn.us/tenncare/Providers/enroll.html

Complete Name: _____ **Title:** _____
(As Shown on License) **(M.D., D.D.S., etc.)**

(Check All That Apply)	_____ **Change of Ownership**
_____ **New Enrollment**	_____ **Reactivation**
_____ **MCC Medicaid No.**	_____ **Adding Practice/Satellite Location**
_____ **Medicare/Medicaid No.**	_____ **Name Change and Tax ID # Change**
Practice Location Address (No P. O. Box #)	**Pay-To Name & Address** (as shown on the I.R.S. and W-9 Form)
Street: _____	**Legal IRS Name:** _____
City: _____	**Name (cont'd)** _____
County: _____	**D/B/A Name:** _____
State: _____	**Street:** _____
Zip Code + 4: _____	**City:** _____
Telephone #: _____	**State:** _____
Fax Number: _____	**Zip Code + 4:** _____
	Telephone #: _____

Federal Tax No. (IRS No.): _____ **Social Security No. (req'd):** _____

Federal Medicare No.: _____ **State Medicaid No.:** _____ **NPI No.:** _____

Medical Specialty: _____

Taxonomy: _____, _____, _____, _____

Briefly describe the services you propose to offer to Medicaid recipients: _____

_____

_____

Board-Certified (Y/N): _____ **Board-Eligible (Y/N):** _____

Name of Board: _____ **DEA No.:** _____

Certificate No.: _____ **Date of Issuance:** _____
Month / Day / Year

Hospital-Affiliated (Y/N): _____ **Hospital-Based (Y/N):** _____

Name of Hospital: _____

Submit copies of professional licenses, and/or certifications, specifically required to operate as a health care provider.

State License No.: _____ **Date Of Issuance:** _____
Month / Day / Year

Have you or any other owner, managing director, etc., related to this application ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? Yes ____ No ____. If yes identify those person(s) by name and provide specifics for Medicaid evaluation. Attach this information to this application.

Please list the full name of every owner, with Social Security number and percent of ownership (required). If owned by corporation, please list corporate officers with same information. Use additional paper ,if necessary.

	Name	Title	SSN	% Ownership
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

EFFECTIVE DATE FOR OPENING/REOPENING OFFICE: _____

EFFECTIVE DATE OF CHANGE OF OWNERSHIP: _____

If change of ownership, please provide the following:

Previous TN Medicaid Provider No. (if any): _____

Previous Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code + 4:** _____

IF A CHANGE OF OWNERSHIP HAS OCCURRED, DO NOT BILL ANY CLAIM FOR DATES OF SERVICE ON OR AFTER THE DATE OF OWNERSHIP CHANGE UNTIL YOU ARE NOTIFIED THAT THIS APPLICATION HAS BEEN ACCEPTED AND ENROLLMENT HAS BEEN COMPLETED. FAILURE TO FOLLOW THIS PROCEDURE MAY RESULT IN RECOUPMENT OF CLAIMS PAID.

Application Surety Statement: "I certify that the information provided on this application is complete and correct to the best of my knowledge."

Provider's Original Signature: _____ **Date:** _____

Printed Name: _____ **Title:** _____

If you belong to a group and authorize all monies due be made payable to the group, please indicate the name and provider number of said group and sign below.

_____ _____

Group Name **Medicare Group Provider No.**

Provider's Original Signature: _____ **Date:** _____

STATE OF TENNESSEE
THE TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
PROVIDER PARTICIPATION AGREEMENT
MEDICAID/TENNCARE TITLE XIX PROGRAM

This statement includes the minimum standards to which the applicant must adhere to be enrolled in the Tennessee Medicaid health care program. Read these statements carefully.

By signing the Provider Participation Agreement, the applicant agrees to adhere to all the conditions listed and is aware that the applicant may be denied entry to or revoked from the program if any conditions are violated. The Provider Participation Agreement must contain an original signature.

1) I have read the contents of the application and information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicaid or other federal health care contractor of this fact immediately;

2) Agree to accept the Medicaid payment as payment in full;

3) To maintain in Tennessee or in the State in which I practice, medical licenses and/or certifications as required;

4) Currently not under a Federal Drug Enforcement Agency (DEA) restriction of prescribing and/or dispensing certification for scheduled drugs (relative to physicians, osteopaths, dentists and pharmacists);

5) Agree to maintain and provide access to Medicaid and/or its agency all Medicaid recipient medical records for five (5) years from the date of service or upon written authorization from Medicaid following an audit, whichever is shorter;

6) Provide medical assistance at or above recognized standards of practice; and

7) Comply with all contractual terms and Medicaid policies as outlined in Federal and State rules and regulations and Medicaid provider manuals and bulletins.

8) That failure to comply with any of the above provisions may subject a provider to actions described in Rule 1200-13-1.21.

Debarment and Suspension.

To the best of its knowledge and belief, the Contractor certifies by its signature to this Contract that the Contractor and its principals:

A. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or State department or Contractor;
B. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, State, or Local) transaction or grant under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
C. are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, State, or Local) with commission of any of the offenses detailed in section b. of this certification; and
D. have not within a three (3) year period preceding this Contract had one or more public transactions (federal, State, or Local) terminated for cause or default.

Applicant name (printed) First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc

Applicant Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc)	**Date**	**Medicare Identification Number**

FOR GROUPS AND ORGANIZATIONS:

Authorized Representative Name (printed) First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc

Title/Position	**Group Name**	**Medicare Identification Number**

Applicant Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc)	**Date**

SUBSTITUTE W-9 FORM

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

1. Please complete general information:

Taxpayer Name: _____ Phone Number: _____

Business Name (if applicable): _____

Address: _____

City: _____ State: _____ ZIP Code: _____

2. Circle the most appropriate category below: (please circle only one)

1) Individual (not an actual business)
2) Joint account (two or more individuals)
3) Custodian account of a minor
4) a. Revocable savings trust (grantor is also trustee)
   b. So-called trust account that is not a legal or valid trust under state law
5) Sole proprietorship (using a social security number for the taxpayer ID)
6) Sole proprietorship (using a federal employer identification number for the taxpayer ID)
7) A valid trust, estate, or pension trust
8) Corporation
9) Association, club, religious, charitable, educational, or other non-profit organization (for entities that are exempt from federal tax, use category 13 below)
10) Partnership
11) A broker or registered nominee
12) Account with the U.S. Department of Agriculture in the name of a public entity that receives agricultural program payments
13) Government agencies and organizations that are tax-exempt under Internal Revenue Service guidelines (i.e., IRC 501(c)3 entities)

3. Fill in your taxpayer identification number below: (please complete only one)

1) If you circled number 1-5 above, fill in your Social Security Number

   __ __ __ - __ __ - __ __ __ __

2) If you circled number 6-13 above, fill in your Federal Employer Identification Number (EIN).

   __ __ - __ __ __ __ __ __ __

Sign and date the form:

Certification – Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number. If I circled category 13 above, I also certify that my agency or organization is tax-exempt per Internal Revenue Service guidelines and not subject to backup withholding.

Signature: _____ Date: _____

Title (if applicable): _____

Janet Moore
Credentialing Specialist
Provider Enrollment Department

CIGNA HealthCare
Medicare Administration
P.O. Box 25226
Nashville, TN 37202-5226

October 16, 2004

DEAR _____ :

Welcome to the Medicare Part B Program. Your application has been processed and approved. Listed below is information on how we processed this application. **Please verify that all information is correct.**

Provider Name:	**DR.** _____
Performing Provider Number:	_____
Unique Physician Identification Number (UPIN):	_____
Legal Name Associated with Number:	_____
Group Pricing Number:	**N/A**
Doing Business As:	**N/A**
You are listed for billing as:	**A Sole Proprietor**
The Payee address is:	_____
	_____
The Practice location is:	_____
Effective Date:	**09/01/2004**

You are listed as a participating provider.

You have been set up to submit claims electronically at this time.

Please notify our office immediately at 1.866.520.4007 if any of the above information is incorrect. Also, remember that all state privilege taxes must be kept current. We look forward to working with you in the future.

Sincerely,

Janet Moore

Janet Moore

Connecticut General Life Insurance Company Part B & DME Contracted Carrier for the Centers for Medicare & Medicaid Services

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Janet Moore
Credentialing Specialist
Provider Enrollment Department

CIGNA HealthCare
Medicare Administration
P.O. Box 25226
Nashville, TN 37202-5226

October 16, 2004

_____
_____
_____

DEAR _____ :

Welcome to the Medicare Part B Program. Your application has been processed and approved. Listed below is information on how we processed this application. **Please verify that all information is correct.**

Provider Name:	**DR.** _____
Performing Provider Number:	_____
Unique Physician Identification Number (UPIN):	_____
Legal Name Associated with Number:	_____
Group Pricing Number:	_____
Doing Business As:	**N/A**
You are listed for billing as:	**An Individual Joining a Group**
The Payee address is:	_____
	_____
The Practice location is:	_____
The other Practice locations are:	_____
Effective Date:	**09/01/2004**

You are listed as a W-2 employee for this location.

You are listed as a participating provider.

You have been set up to submit claims electronically at this time.

Please notify our office immediately at 1.866.520.4007 if any of the above information is incorrect. Also, remember that all state privilege taxes must be kept current. We look forward to working with you in the future.

Sincerely,

Janet Moore

Janet Moore

Connecticut General Life Insurance Company Part B & DME Contracted Carrier for the Centers for Medicare & Medicaid Services

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 GREAT CIRCLE ROAD
NASHVILLE, TENNESSEE 37243 – 1700

TENNCARE / MEDICAID BENEFITS LIMITED REASSIGNMENT AUTHORIZATION

PROVIDERS WHO HAVE STATE ASSIGNED MCC MEDICAID PROVIDER NUMBERS AND HAVE RECEIVED THEIR MEDICARE NUMBERS

Note: This form may be used when the individual and group providers have received their assigned MCC Medicaid number(s). Both must be linked by the same tax identification number and address. Your Medicare Welcome Letter(s) must be returned with this completed form. You will not have to complete any new additional application(s).

Name: _____ **Group MCC Medicaid Number:** _____

Address: _____

_____

The undersigned physician agrees that said Medicare group is authorized to bill for services furnished and that monies due shall be made payable to the group.

NAME AND SIGNATURE OF PHYSICIAN	MCC INDIVIDUAL PROVIDER NUMBER	MEDICARE INDIVIDUAL PROVIDER #	MEDICARE GROUP PROVIDER NUMBER
NAME _____	_____	_____	_____

SIGNATURE _____

GROUP NPI NO. _____

INDIV. NPI NO. _____

Medicare Welcome Letter(s) Must Be Returned With This Form!

National Provider Identifier (NPI) Collection Form
(Individual/ Solo Practices)

Any form not containing all required fields will be rejected.

Section 1 – Provider General Information
(Please make additional copies if required)

Provider Last Name	First Name	Middle	Title

Existing Medicaid ID's	SSN	EIN Number

Section 2 – NPI Information

NPI Number _____

Taxonomy Codes

Section 3 – Primary Practice Location (As Entered on NPPES)

Address _____

City	State	ZIP

Phone Number	Fax Number	Provider e-mail Address

Section 4 – Contact Information

Name of Individual Completing Form _____

Phone Number	Fax Number	Contact e-mail Address

Signature _____ **Title** _____

NPI Collection Form Surety Statement:
"I certify that the information provided on this application is complete and correct to the best of my knowledge."

Instructions
Individual/Solo Practice

Send the completed NPI Collection Form and a copy of the NPPES confirmation via one of the following means:

Mail	Provider Enrollment Attn: NPI Collection 310 Great Circle Rd. Nashville, TN 37243 - 1700
Fax	(615) 248-4386 or (866) 456-8059
Field	**Instruction**
Section 1 – Provider General Information	
Provider Last Name	(Required) Enter the provider's last name.
First Name	(Required) Enter the provider's first name.
Middle	(Optional) Enter the provider's middle name.
Title	(Required) Enter the provider's title.
Existing Medicaid ID's	(Required) Enter all currently assigned Medicaid provider numbers.
SSN	(Required) for an individual provider. Enter the Social Security Number.
EIN Number	(Required) Enter the Employer Identification Number (could be SSN).
Section 2 – NPI Information	
National Provider Identifier	(Required) Enter the National Plan and Provider Enumeration System (NPPES) assigned NPI.
Taxonomy Codes	(Required) Enter the Taxonomy codes associated with the assigned NPI.
Section 3 – Primary Practice Location	
Address	(Required) Enter the primary practice location line 1 address of the provider as entered in the NPPES.
City	(Required) Enter the primary practice location City of the provider as entered in the NPPES.
State	(Required) Enter the primary practice location State of the provider as entered in the NPPES.
ZIP	(Required) Enter the primary practice location ZIP of the provider as entered in the NPPES. If known, include the ZIP +4.
Phone Number with area code	(Required) Enter the primary practice location phone number of the provider as entered in the NPPES.
Fax Number with area code	(Optional) Enter the primary practice location fax number of the provider as entered in the NPPES.
Provider e-mail Address	(Optional) Enter the primary practice location e-mail address of the provider as entered in the NPPES.
Section 4 – Contact Information	
Name of Individual Completing Form	(Required) Enter the name of the individual completing this form.
Phone Number with area code	(Required) Enter the phone number of the individual completing this form.
Fax Number with area code	(Optional) Enter the fax number of the individual completing this form.
Contact e-mail Address	(Optional) Enter the e-mail address of the individual completing this form.
Signature and Title	Signature and Title of the person who has legally binding authority to provide information to the Bureau of TennCare with regards to the provider identified on the form.

National Provider Identifier (NPI) Collection Form
(Group Practices)

Any form not containing all required fields will be rejected.

Section 1 – Provider General Information

Business Name _____

Doing Business As (Name) _____

_____ _____ _____

Medicaid ID **EIN** **NPI**

Taxonomy Codes _____ _____ _____

_____ _____ _____

Section 2 – NPI Information

(Please Complete this Section for each Individual Provider that is associated with your Group. Please Make additional copies if required)

Provider Name	Medicaid ID	NPI	SSN	Taxonomy	Taxonomy

Section 3 – Primary Practice Location (As Entered on NPPES)

Address _____

_____ _____ _____

City **State** **ZIP**

_____ _____ _____

Phone Number **Fax Number** **Provider Email Address**

Section 4 – Contact Information

Name of Individual Completing Form _____

_____ _____ _____

Phone Number **Fax Number** **Contact Email Address**

Signature _____ **Title** _____

NPI Collection Form Surety Statement:
"I certify that the information provided on this application is complete and correct to the best of my knowledge."

Instructions
Group Practices

Send the completed NPI Collection Form via one of the following means:

Mail	Provider Enrollment Attn: NPI Collection 310 Great Circle Rd. Nashville, TN 37243 - 1700
Fax	(615) 741-0028
Field	**Instruction**
Section 1 – Provider General Information and NPI Information	
Provider Business Name	(Required) Enter the provider's name (Facilities, Agencies, Groups, Hospitals, etc.).
D/B/A Name	(Required If Applicable).
Medicaid ID No.	(Required) Enter the 7-digit Medicaid provider number.
EIN	(Required for a business entity) Enter the Employer Identification Number.
National Provider Identification Number	(Required) Enter the National Plan and Provider Enumeration System (NPPES) assigned NPI.
Section 2 – Group Member - NPI Information	
Provider Name	(Required) Enter the individual provider name linked to this group number.
Medicaid ID No.	(Required) Enter the 7-digit Medicaid provider number.
NPI Individual Provider Identifier	(Required) Enter the National Plan and Provider Enumeration System (NPPES) assigned NPI.
Social Security Number	(Required) Enter the Individual Provider SSN.
Taxonomy Codes	(Required) Enter the Taxonomy codes associated with the assigned NPI.
Section 3 – Primary Practice Location	
Address	(Required) Enter the primary practice location address of the provider as entered in the NPPES.
City	(Required) Enter the primary practice location City of the provider as entered in the NPPES.
State	(Required) Enter the primary practice location State of the provider as entered in the NPPES.
ZIP	(Required) Enter the primary practice location zip of the provider as entered in the NPPES. If known, include the ZIP +4.
Phone Number with area code	(Required) Enter the primary practice location phone number of the provider as entered in the NPPES.
Fax Number with area code	(Optional) Enter the primary practice location fax number of the provider as entered in the NPPES.
Provider Email Address	(Optional) Enter the primary practice location e-mail address of the provider as entered in the NPPES.
Section 4 – Contact Information	
Name of Individual Completing Form	(Required) Enter the name of the individual completing this form.
Phone Number with area code	(Required) Enter the phone number of the individual completing this form.
Fax Number with area code	(Optional) Enter the fax number of the individual completing this form.
Contact Email Address	(Optional) Enter the email address of the individual completing this form.
Signature/Title	Signature and Title of the person who has legally binding authority to provide information to the Bureau of TennCare with regards to the provider identified on the form.